Madigan Army Medical Center
Referral Guidelines

Knee Pain – Anterior

Diagnosis/Definition

Knee pain localized to the anterior portion of the knee, either retropatellar or peripatellar. Usually a gradual, non-traumatic onset aggravated with increased activity, running, squatting, stair climbing or prolonged sitting. Symptoms normally decrease with rest.

Initial Diagnosis and Management

- History and physical examination
- Plain films not required
- NSAIDs
    - Adults - 200 to 400 milligrams (mg) every four to six hours as needed for up to 2 weeks. Example: Ibuprofen
    - Take tablet or capsule forms of these medicines with a full glass (8 ounces) of water.
    - Do not lie down for about 15 to 30 minutes after taking the medicine. This helps to prevent irritation that may lead to trouble in swallowing.
    - To lessen stomach upset, these medicines should be taken with food or an antacid.
- Avoidance of aggravating activities (profile for active duty soldiers)
- Strengthening exercises for quadriceps, stretching exercises for quads, hamstrings and calf muscle
- Ice PRN after activities
- Compression wrap is contraindicated
- Patient education (refer patient to PT for Retropatellar Pain Syndrome (RPPS) class)
- Please refer to the Clinical standard on knee pain.

Ongoing Management and Objectives

- Resolution or decreasing symptoms in three to four weeks
- If no resolution:
    - Trial of alternate NSAID
    - Trial of neoprene sleeve with patella opening
    - Obtain plain films with sunrise views
    - Do not order an MRI. Orthopedic clinic will order, or recommend, if patient meets pre-surgery criteria

Indication a profile is needed

- Any limitations that affect strength, range of movement, and efficiency of feet, legs, lower back and pelvic girdle.
- Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that may prevent moderate marching, climbing, timed walking, or prolonged effect.
- Defects or impairments that require significant restriction of use.

Specifications for the profile

- Months 1-3
    - No running, jumping, marching, squatting.
- Months 4-6
    - Gradual transition into own pace and distance

Patient/Soldier Education or Self care Information

- See attached sheet
- Demonstrate deficits that exist
    - Describe/show soldier his/her limitations
- Explain injury and treatment methods
    - Use diagram attached to describe injury, location and treatment.
- Instruct and demonstrate rehab techniques
    - Demonstrate rehab exercises as shown in attached guide
    - Warm up before any sports activity
    - Participate in a conditioning program to build muscle strength
    - Do stretching exercises daily
- Ask the patient to demonstrate newly learned techniques and repeat any other instructions.
- Fine tune patient technique
    - Correct any incorrect ROM/stretching demonstrations or instructions by repeating and demonstrating information or exercise correctly.
- Encourage questions
    - Ask soldier if he or she has any questions
- Give supplements such as handouts
- Schedule follow up visit with Primary Care
    - If pain persists
    - The pain does not improve as expected
    - Patient is having difficulty after three days of injury
    - Increased pain or swelling after the first three days
    - Patient has any questions regarding care

Indications for Specialty Care Referral

- History of joint locking and giving way
- Question of underlying instability
- Prolonged effusion > 10 to 14 days
- R/O fractures, septic joints, rheumatoid arthritis, etc. should be referred to appropriate specialty clinic (Orthopedics or Rheumatology)
- Refer to Physical Therapy if none of the above but progression of atrophy or persistent symptoms despite initial management.
- Completed full course of rehabilitation and have any of the following concerning symptoms: catching, locking, effusions, instability, warmth or erythema (Orthopedics referral indicated).

Criteria for Return to Primary Care

- Resolution of symptoms
- If persistence of anterior knee pain > 6-12 months, without concerning symptoms as described above, consider permanent profiling with patient specific limitations.

- If meets criteria for P3 profile, referral to MAMC MEB section for MEB is appropriate. MEB can be initiated by primary care.

Please also see the Knee Clinical Practice Guideline.

Last Review for this Guideline: **May 2009**
Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator